Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1993

BARBARA J. TREGONING; JOE W. HUTCHINS; JOANNE HARTLERODE; AND RIPLEY LANCE PETERSON, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Petitioners,

vs.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY,

Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Do individual participants and beneficiaries under an ERISA regulated health and welfare benefits plan have a cause of action for payment or reimbursement of plan covered medical expenses against a fiduciary who has breached fiduciary duties owed to such individuals under § 502(a) of ERISA, [29 U.S.C. § 1132(a)], clarifying this Court's holding in *Massachusetts Mutual Insurance Company v. Russell?*

2. Should respondent be equitably estopped from denying coverage on petitioners' claim for payment or reimbursement of medical expenses because of respondent's conduct toward petitioners and representations to various health care providers that there was in fact coverage under the ERISA plan?

3. Do petitioners have a cause of action against respondent pursuant to § 405(a), (c)(1), (2) of ERISA, [29 U.S.C. § 1105(a), (c)(1), (2)] for a breach of duty by a co-fiduciary when respondent was aware that petitioners' employer was failing to make claims fund replenishment and failing to transmit premiums contributed by petitioners, but failed to so inform petitioners?

LIST OF PARTIES

The parties to the proceedings below were petitioners, Barbara J. Tregoning; Joe W. Hutchins; JoAnne Hartlerode; and Ripley Lance Peterson, individually and on behalf of all others similarly situated, and respondent, American Community Mutual Insurance Company.

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Petitioners,

vs.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY,

Respondent.

Petition for Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioners Barbara J. Tregoning, Joe W. Hutchins, JoAnne Hartlerode, and Ripley Lance Peterson, individually and on behalf of all others similarly situated, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United

States Court of Appeals for the Sixth Circuit holding that petitioners had no individual right to recover from respondent for breach of fiduciary duties, and affirming the District Court's Order granting summary judgment to respondent.

OPINIONS BELOW

The opinion of the Court of Appeals is reported as *Tregoning, et al. v. American Community Mutual Insurance Company*, 12 F.3d 79 (6th Cir. 1993), and is reprinted in the Appendix to this Petition, *infra* at 1a. The unpublished order of the District Court for the Western District denying Petitioners' Motion for Reconsideration appears in the Appendix hereto, *infra* at 11a. The written opinion of the District Court for the Western District of Michigan denying Petitioner's Motion for Reconsideration is reported as *Tregoning, et al. v. American Community Mutual Insurance Company*, 815 F. Supp. 1054 (W.D. Michigan, S.D. 1992), and is reprinted in the Appendix hereto, *infra* at 12a. The written opinion and order of the District Court for the Western District of Michigan granting respondent's Motion for Summary Judgment, is reported as *Tregoning, et al. v. American Community Mutual Insurance Company*, 815 F. Supp. 1054 (W.D. Michigan, S.D. 1992), and is reprinted in the Appendix hereto, *infra* at 17a.

STATEMENT OF JURISDICTION

Subject matter jurisdiction of this Court is invoked because a federal question is involved pursuant to Title 28, U.S.C. § 1331. The federal law at issue is the Employee Retirement Income Security Act of 1974 ("ERISA"), Title 29, U.S.C. § 1001, *et seq.* The Court of Appeal's opinion in this matter was filed on December 17, 1993. This Court's appellate jurisdiction is invoked under Title 28, U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

29 U.S.C. § 1104. **Fiduciary duties**

(a) Prudent man standard of care. (1) Subject to sections 403(c) and (d)[29 U.S.C. § 1103(c) and (d)], 4042 [29 U.S.C. § 1342], and 4044 [29 U.S.C. § 1344], a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title or title IV.

* * *

29 U.S.C. § 1105. **Liability for breach by co-fiduciary**

(a) Circumstances giving to liability. In addition to any liability which he may have under any other provision of this part, a fiduciary with respect to a plan shall be liable for a breach of fiduciary responsibility of another fiduciary with respect to the same plan in the following circumstances:

(1) if he participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach;

(2) if, by his failure to comply with section 404(a)(1) [29 U.S.C. §1104(a)(1)] in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or

(3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

* * *

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities. (1) The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (B) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan. (2) If a plan expressly provides for a procedure described in paragraph (1), and pursuant to such procedure any fiduciary responsibility of a named fiduciary is allocated to any person, or a person is designated to carry out any such responsibility, then such named fiduciary shall not be liable for an act or omission of such person in carrying out such responsibility except to the extent that—

(A) the named fiduciary violated section 404(a)(1) [29 U.S.C. § 1104(a)(1)]—

(i) with respect to such allocation or designation.

(ii) with respect to the establishment or implementation of the procedure under paragraph (1), or

(iii) in continuing the allocation or designation; or

(B) the named fiduciary would otherwise be liable in accordance with subsection (a).

(3) For purposes of this subsection, the term "trustee responsibility" means any responsibility provided in the plan's trust instrument (if any) to manage or control the assets of the plan, other than a power under the trust instrument of a named fiduciary to appoint an investment manager in accordance with section 402(c)(3) [29 U.S.C. § 1102(c)(3)].

29 U.S.C. § 1109. **Liability for Breach of Fiduciary Duty.**

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the Court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of Section 411 of this Act.

(b) No fiduciary shall be liable with respect to a breach of fiduciary duty under this title if such breach was committed before he became a fiduciary or after he ceased to be a fiduciary.

29 U.S.C. § 1132. **Civil Enforcement.**

(a) *Persons empowered to bring a civil action.* A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [29 U.S.C. 1109];

(3) by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 105(c) [29 U.S.C. § 1025(c)];

(5) except as otherwise provided in subsection (b), by the Secretary (A) to enjoin any act or practice which violates any provisions of this

title, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this title; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (l).

* * *

STATEMENT OF THE CASE

This case presents important issues concerning whether *Massachusetts Mutual Life Insurance Company v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985) (hereinafter "*Russell*") precludes employees and beneficiaries of a group insurance policy from recovering their unpaid and un-reimbursed medical bills from the insurance company who administered the plan and who breached fiduciary duties to the beneficiaries by failing to inform them the plan was not being funded by their employer. The opinion of the Sixth Circuit Court of Appeals held that although respondent was a fiduciary, and therefore owed fiduciary duties to petitioners, that no cause of action existed for petitioners individually because only the plan itself could recover for a breach of fiduciary duty. This holding was based on dicta in *Russell, supra.*

Petitioners were all employees in 1989 and 1990 of Watervliet Paper Company ("Watervliet") located in Watervliet, MI. Petitioners were participants in a group health insurance plan funded by Watervliet and administered by respondent. Petitioners paid a portion of the premium via the mechanism of a payroll deduction. The group plan was a minimum funded policy, which meant that respondent paid health claims on behalf of Watervliet from a claims fund deposited by Watervliet with respondent. Respondent would then bill Watervliet on a monthly basis for reimbursement of the claims fund, plus an additional charge (the

so-called minimum premium) reflecting respondent's cost of administration and profit margin.

Watervliet failed to timely reimburse the claims fund, and therefore respondent sent various past due notices and letters threatening termination of the policy in October, November, and December of 1989. When Watervliet's failure to fully reimburse the claims fund continued, respondent suspended payment of insurance claims in January of 1990. After receipt of a partial payment by Watervliet, respondent reinstated the policy. Respondent suspended and then reinstated the group policy at least two more times as Watervliet fell further and further behind in its replenishment of the claims fund.

Respondent never notified petitioners, nor any other employees of Watervliet, that 1) Watervliet was not paying respondent; (2) respondent had suspended payment of claims several times; (3) Watervliet appeared to be in serious financial trouble; nor that (4) respondent might terminate the entire group policy because of Watervliet's failure to make payments.

Throughout the first few months of 1990, respondent continued to pay health insurance claims incurred prior to December 31, 1989.Therefore, petitioners were unaware of any problem with the group insurance plan. In March of 1990, new prescription cards were issued by respondent to petitioners and the other employees of Watervliet because the old cards were due to expire. In addition, respondent utilized the services of another company, Intracorp, Inc. ("Intracorp") to pre-certify the reasonableness and the necessity of various medical procedures needed by Watervliet employees. Throughout this time, respondent allowed Intracorp to continue to pre-certify Watervliet employees under the group plan. Moreover, respondent was actually contacted by health care providers for at least two of the named petitioners in March of 1990, and respondent verified that there was insurance coverage in effect under the group plan.

On April 12, 1990, respondent informed Watervliet that it was terminating the group policy retroactively to February 28, 1990. This information was not communicated to the employees by either respondent or Watervliet. On May 17, 1990, respondent informed Watervliet that the effective date of the termination of the group policy was being moved back to December 31, 1989. Respondent's \pre-certification agent, Intracorp, continued to communicate with the employees and pre-certify medical services until at least May 9, 1990 when it was instructed by respondent that the group policy had been terminated. In early June of 1990, petitioners, along with other employees of Watervliet, discovered their employer was entering into bankruptcy and that respondent was refusing to pay or reimburse claims for health care costs incurred after December 31, 1989.

This case was originally filed as a putative class action lawsuit in Berrien County Circuit Court in the State of Michigan. Respondent removed the case to the United States District Court for the Western District of Michigan, on the basis that a federal question was involved, *i.e.*, the Employee Retirement Income Security Act of 1974 ("ERISA") pursuant to 28 U.S.C. § 1331. Petitioners then amended their complaint to add a cause of action under ERISA.

Competing motions for summary judgment were filed by petitioners and respondent in the trial court. Respondent's motion for summary judgment was granted and petitioners' motion for summary judgment was denied by the opinion and order of July 15, 1992. The trial court held that respondent was not a fiduciary and therefore owed no fiduciary duties to petitioners. Petitioners filed a motion for reconsideration with the trial court, which was denied by the trial court's order of August 27, 1992, issued in accordance with the court's written opinion of August 27, 1992.

Petitioners timely appealed to the United States Sixth Circuit

Court of Appeals. Appellate jurisdiction in the Court of Appeals was premised upon 28 U.S.C. § 1291.

On December 17, 1993, a panel of the United States Court of Appeals for the Sixth Circuit issued its opinion affirming the grant of summary judgment by the trial court. The opinion held that respondent was a fiduciary, but that the fiduciary duties ran to the group plan as a whole, rather than the individuals. Therefore, the Sixth Circuit's opinion held that petitioners could not recover their unpaid and un-reimbursed health care expenses.

REASONS FOR GRANTING THE WRIT

I.

THIS COURT'S DECISION IN *RUSSELL* DOES NOT PRECLUDE PETITIONERS' § 502 CLAIM.

Certiorari should be granted because the time has come for this Court to clarify its holding in *Russell*, because its *dicta* has been blindly relied upon by several Court of Appeal's decisions to bar any remedy for an individual damaged by a breach of duty by a fiduciary. The opinion below of the Sixth Circuit Court of Appeals expressly relied upon *Russell* to justify its holding that petitioners had no remedy for payment and/or reimbursement of medical claims from respondent, despite respondent's breach of fiduciary duties. Those breaches of fiduciary duty included failing to notify petitioners and other participants of the group plan that the employer was not making claims fund replenishment and not transmitting premiums contributed to by the employees, as well as affirmative misrepresentations that the group plan was in effect when, in fact, it had been repeatedly suspended.

The opinion of this Court in *Russell* was written by Justice Stevens who framed the issue before the court as follows:

> The question presented for decision is whether, under the Employee Retirement Income Security Act of 1974 (ERISA), a fiduciary to an employee benefit plan may be held personally liable to a plan participant or beneficiary for extra-contractual compensatory or punitive damages caused by improper or untimely processing of benefit claims.

473 U.S. at 136.

Russell involved a beneficiary under an employee benefit plan who was not timely paid benefits available to her under said plan. Because of a 132 day delay in payment of benefits, suit was filed against the insurance company, which was both plaintiff's employer and administrator of the plan, seeking compensatory and punitive damages for violations of fiduciary duty under § 409(a) [29 U.S.C. § 1109(a)] of ERISA. In *Russell*, the claim was based entirely on § 409(a). Justice Stevens stated in a footnote as follows:

> Because respondent relies entirely on Section 409(a), and expressly disclaims reliance on Section 502(a)(3), we have no occasion to consider whether any other provision of ERISA authorizes recovery of extra-contractual damages. Tr. of Oral Arg. 31-32.

473 U.S. at 139, n.5. The actual holding of this Court in *Russell* is succinctly stated in Section III of Justice Stevens opinion as follows:

> Thus, the relevant text of ERISA, the structure of the entire statute, and its legislative history all support the conclusion that in Section

> 409(a) Congress did not provide, and did not intend the judiciary to imply, a cause of action for extra-contractual damages caused by improper or untimely processing of benefit claims.

473 U.S. at 148.

Justices Brennan, White, Marshall, and Blackmun concurred in the judgement in *Russell* with Justice Brennan writing the concurring opinion. Justice Brennan explained the narrow scope of the actual decision in Russell as follows:

> I agree with the Court's decision today that Section 409 is more fairly read in context as providing "remedies that would protect the entire plan" rather than individuals, ante, at 3090, and that participants and beneficiaries accordingly must look elsewhere in ERISA for personal relief. Indeed, since Section 502(a)(3) already provides participants and beneficiaries with "other appropriate equitable relief ... to redress [ERISA] violations," there is no reason to construe Section 409 expansively in order to bring these individuals under the penumbra of "equitable or remedial relief".
>
> This does not resolve, of course, whether and to what extent extra-contractual damages are available under Section 502(a)(3). This question was not addressed by the courts below and was not briefed by the parties and amici. Thus the Court properly emphasizes that "we have no occasion to consider whether any other

> provision of ERISA authorizes recovery of extra-contractual damages." Ante, at 3088, n. 5. Accordingly, we save for another day the questions (1) to what extent a fiduciary's mishandling of a claim might constitute an actionable breach of the fiduciary duties set forth in Section 404(a), and (2) the nature and extent of the "appropriate equitable relief ... to redress" such violations under Section 502(a)(3).

473 U.S. at 150. Prophetically, Justice Brennan noted that there was potentially far reaching dicta in the majority opinion despite the narrowness of the holding itself. He went on to state:

> To the extent the Court suggests that administrators might not be fully subject to strict fiduciary duties to participants and beneficiaries in the processing of their claims and to traditional trust law remedies for breaches of those duties, I could not more strongly disagree.

473 US at 151-152. Justice Brennan analyzed the interplay between Section 404 and 502 of ERISA as follows:

> Section 502(a)(3) authorizes the award of "appropriate equitable relief" directly to a participant or beneficiary to "redress" "any act or practice which violates any provision of this title or the terms of the plan." This section and Section 404(a)'s fiduciary-duty standards both appear in title I, which is entitled "PROTECTION OF EMPLOYEE BENEFIT RIGHTS". A beneficiary therefore may obtain

> "appropriate equitable relief" whenever an administrator breaches the fiduciary duties set forth in Section 404(a). Accordingly, an administrator's claims processing duties, and a beneficiary's corresponding remedies are not at all necessarily limited to the terms of Sections 502(a)(1)(b) and 503. In light of the Court's narrow holding, see ante, at 3089, n. 5, further consideration of these important issues remains open for another day when the disposition of a controversy might really turn on them.

473 U.S. at 153-154.

That day has come. Petitioners expressly rely on Section 502(a) of ERISA in their claim for repayment and/or reimbursement of health care bills. Respondent's breach of fiduciary duty in failing to inform petitioners of their employer's failure to make claims fund replenishment and premium payments proximately caused petitioners, individually and on behalf of all others similarly situated, to incur hundreds of thousands of dollars in health care bills without any warning that the group plan itself was consistently under-funded and had been repeatedly suspended. Respondent also affirmatively represented to health care providers that there was coverage under the group plan even though respondent knew of the shaky financial status of the plan and that numerous suspensions of payments had already occurred.

Thus, the facts of the case at bar, the theory of recovery and the relief sought are all far different from those involved in the *Russell* decision. *Russell* involved (1) a plaintiff who had received all of her contractual benefits under the plan; (2) a claim for compensatory and punitive damages, and; (3) a claim brought solely under Section 409. Petitioners in this litigation however,

have never received the payments due them under the plan, are not seeking punitive damages, and are seeking "other appropriate equitable relief" under § 502(a)(3). Given these important factual and legal differences in the two cases, this Court's decision in *Russell* should not control the outcome here.

It is important to note that the equitable relief sought by petitioners under § 502(a)(3) is simply to have the unpaid and unreimbursed medical bills paid by respondent. Had petitioners been informed by respondent in January of 1990 that payment of claims was being suspended because of Watervliet's failure to make claims fund replenishment and minimum premium payments, petitioners would have made other arrangements for health insurance coverage. Respondent's retroactive termination of the group plan and refusal to pay any health care bills incurred after December 31, 1989, which was not communicated to petitioners until June of 1990, left the approximately 200 employees of Watervliet (not to mention the local health care providers) with six months accumulated health care expenses in the range of $500,000.00. It is these bills which petitioners seek to have paid and/or reimbursed in their suit for equitable relief. It was always intended that beneficiaries of an ERISA plan would have access to this type of relief. As Justice Brennan stated in his concurring opinion in *Russell*:

> ERISA's legislative history also demonstrates beyond question Congress intended to engraft trust-law principles onto the enforcement scheme, see Note 6, supra, and a fundamental concept of trust law is that courts "will give to the beneficiary of a trust such remedies as are necessary for the protection of their interests."[16]

---

16. 3 A. Scott, Law of Trusts § 199, p. 1638 (1967). See also Restatement (Second) of Trusts § 205, and Comment

> a (1959) (beneficiary entitled to a remedy "which will put him in the position in which he would have been if the trustee would not have committed the breach of trust"); Bogert & Bogert, Trusts and Trustees § 862.

473 U.S. at 156-157.

Given the clear intent that equitable relief be available to the victims of a fiduciary who has breached its fiduciary duty, it is inconceivable that the Court of Appeals below would not allow petitioners to individually recover unpaid and un-reimbursed health costs on the theory that only the abstract entity of the plan itself could recover damages for a breach of fiduciary duty. What the Sixth Circuit opinion utterly failed to recognize is that the duties, which were breached by respondent, all ran directly to individuals and not to an abstract entity. Respondent failed to let the individual petitioners know of the repeated suspensions of the group plan and the fact that their employer was obviously in severe financial difficulty. Respondent's agent, Intracorp, communicated directly with individual petitioners in the course of pre-certifying the reasonableness and necessity of their medical treatment. Finally, respondent communicated to individual health care providers in Southwestern Michigan that there was insurance coverage under the group plan in effect. Under these circumstances, there is no point in allowing a remedy to a non-existent entity called "the plan". Neither the plan, nor the bankrupt employer incurred unpaid and un-reimbursed health care costs because of respondent's breach of duty; only the individual petitioners and others similarly situated were so damaged. These individuals should have the right under § 502(a)(3) to be made whole, to be put in the position they would have been in, but for respondent's breach of fiduciary duty, *i.e.*, having their health care claims paid.

The opinion below of the Sixth Circuit Court of Appeals never discussed the § 502(a)(3) cause of action of petitioners. The

opinion below merely cited *Russell* and noted that under § 409 as interpreted by *Russell* "... the liability of a fiduciary is to reimburse the plan, not the individual participants". 12 F.3d at 83. Surely, the time has come to analyze a § 502(a) claim on its own merits and not blithely assume that the statutory limitations of a § 409 claim, as interpreted by this Court in *Russell*, also apply to § 502(a).

Other decisions have similarly broadly interpreted *Russell* to bar a claim by an individual for a breach of fiduciary duty under § 502(a). *See McMahon v. McDowell*, 794 F.2d 100, 111 (3d Cir.) *cert. denied*, 479 U.S. 971, 107 S. Ct. 473, 93 L. Ed. 2d 417 (1986); *Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1162 n.7 (3d Cir. 1990). *Lee v. Burkhart*, 991 F.2d 1004 (2d Cir. 1993); *Sokol v Bernstein*, 803 F.2d 532 (9th Cir. 1986). The Seventh Circuit has openly questioned the wisdom of this interpretation of *Russell*, even while following it. In *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir. 1992), *cert. denied*, 113 S. Ct. 61, 121 L. Ed. 2d 29 (1992), the Seventh Circuit considered whether individual claims for extra-contractual compensatory and punitive damages could be brought under either § 502(a)(1)(B), or § 502(a)(3)(B). The Seventh Circuit stated in *Harsch* as follows:

> We can see — particularly as illustrated by the case at bar — good reasons to allow beneficiaries to recover extra-contractual damages under ERISA. But the Fourth Circuit, relying on *Russell*, has held that extra-contractual compensatory damages are not available under § 502(a)(1)(B). See *Reinking v. Philadelphia American Life Insurance Company*, 910 F2d. 210 (4th Cir. 1990) (denying claim for extra-contractual damages for emotional stress). Although the policy implications in cases such as the one before us

> may be troubling, we have no choice but to agree. Any other conclusion would appear to be at odds with the plain meaning of the Supreme Court's statements in *Russell*.

956 F.2d at 655.

One Court of Appeals opinion had the vision to follow only the holding in *Russell*, and not the *dicta*. Ironically, it was another panel of the Sixth Circuit which decided *Warren v. Society National Bank*, 905 F.2d 975 (6th Cir. 1990), *cert. denied*, 111 S. Ct. 2256, 114 L. Ed. 2d 709 (1991). In *Warren*, the Sixth Circuit held that an individual beneficiary under an ERISA plan could recover damages pursuant to § 502(a)(3) for the increased liability incurred as a result of the plan administrator's breach of fiduciary duty. The panel of the Sixth Circuit which decided *Warren* specifically distinguished *Russell*, in part because of the § 502(a)(3) statutory basis of the *Warren* plaintiff's claim. 905 F.2d at 980. Curiously enough, the opinion below of the Sixth Circuit did not even mention *Warren*, let alone attempt to reconcile the decisions.

II.

RESPONDENT SHOULD BE EQUITABLY ESTOPPED FROM DENYING COVERAGE.

Petitioners also make the claim that respondent should be equitably estopped from raising the defense of lack of assets in the claims fund as a defense to this action for payment and reimbursement of the medical bills. It is petitioners' position that both the conduct and misrepresentations of respondent require this equitable remedy. The egregious conduct of respondent included (1) failure to advise the individual plan participants of the poor financial status of the plan, and the fact that there had been

numerous suspensions of payment of claims; (2) the issuing of new prescription cards in March of 1990 by respondent; and (3) continuing to have respondent's agent, Intracorp, pre-certify the reasonableness and necessity of medical procedures into May of 1990. In addition to this conduct, respondent affirmatively represented to at least two health care providers that coverage was in effect under the group plan in March of 1990.

The Sixth Circuit rejected petitioners' equitable estoppel claim. The opinion below analyzed the equitable estoppel issue as follows:

> The Sixth Circuit has incorporated the doctrine of equitable estoppel into the federal common law of contracts, so far as the agreement at issue is before the federal court as an ERISA claim. *Armistead v. Verniton Corp.*, 944 F.2d 1287, 1298 (6th Cir. 1991). The elements of equitable estoppel are:
>
> > 1) conduct or language amounting to a representation of material fact; 2) awareness of the true facts by the party to be estopped; 3) an intention on the part of the party to be estopped that the representation be acted on, or conduct toward the party asserting the estoppel such that the latter has a right to believe that the former's conduct is so intended; 4) unawareness of the true facts by the party asserting the estoppel; and 5) detrimental and justifiable reliance by the party asserting estoppel on the representation.

. . .

> Assuming that the plaintiffs could meet their burden as to the first three *Armistead* elements, summary judgment is still appropriate because they cannot meet the last two elements, namely "unawareness of the true facts by the party asserting the estoppel," and "detrimental and justifiable reliance."

12 F.3d at 83-84.

Apparently, the basis for the Sixth Circuit's decision was the fact that respondent had retained the contractual right to pay claims only so long as Watervliet's account was in good standing, and the fact that Intracorp's pre-certification letters to the individual plan participants included the caveat that pre-certification was not a guarantee that coverage was in effect. The Sixth Circuit apparently missed the point that it was the previously mentioned conduct and misrepresentations of respondent that led petitioners (as well as health care providers in Southwest Michigan) to believe coverage was in effect.

In a case with similar, but much less egregious facts, the Second Circuit Court of Appeals recognized that an equitable estoppel claim was appropriate. In *Lee v. Burkhart, supra*, participants in an ERISA group health plan sought reimbursement of medical costs from the insurance company administering the plan. The insurer refused to reimburse the medical costs because of the bankruptcy of the plan's self-insured sponsor. The plaintiff's theory in *Lee* centered not on any misconduct of the insurer, but instead the fact that the plan participants never understood that the plan was self-funded as opposed to a traditional insurance policy. Given these facts, the Second Circuit predictably affirmed the District Court's grant of summary judgment holding the individual

participants had failed to state a cause of action under ERISA. Obviously the key difference between the *Lee* case and the case at bar was the absence in *Lee* of any misconduct or misrepresentations proximately causing plaintiff's damages. There was no allegation in *Lee* that the insurer had any knowledge of the financial problems of the self-insured plan sponsor.

Significantly, however, the Second Circuit noted that an equitable estoppel theory would have been appropriate (had it been pled). The Second Circuit stated:

> To be sure, P and W's alleged failure to provide participants with a plan description violated a statutory obligation that can be fairly characterized as a fiduciary duty. If, therefore, Connecticut General were a fiduciary and had actual knowledge that P & W failed to furnish participants with the plan description, and took no step to correct that breach of duty, Connecticut General might, itself, have breached a fiduciary obligation, and that breach, together with the detrimental reliance alleged in the pleadings, would estop Connecticut General from asserting the lack of funding from P & W as a defense to payment of these claims. Connecticut General would then have placed itself in the unfortunate position of any insurer that issues a policy that omits to state a condition.

991 F.2d at 1011.

Surely, if the insurer in *Lee* could be estopped simply by failing to correct the plan sponsor's refusal to furnish a plan

description, then *a fortiorari* respondent's failure in the instant case to inform the individual plan participants that their employer was not replenishing the claims fund and was not transmitting petitioners' premium payments, and that payment of claims under the plan had been repeatedly suspended, demands application of equitable estoppel.

III.

RESPONDENT IS LIABLE FOR BREACH OF DUTY BY A CO-FIDUCIARY PURSUANT TO *WILLETT*.

The opinion below of the Sixth Circuit also completely failed to address the question whether petitioners had a cause of action against respondent for breach of duty by a co-fiduciary pursuant to § 405(a)(c) of ERISA (29 U.S.C. 1105(c)(2)). The Eleventh Circuit recognized such a cause of action in a case involving remarkably similar facts in *Willett v. Blue Cross & Blue Shield of Alabama*, 953 F.2d 1335 (11th Cir. 1992)

The facts of *Willett* are strikingly similar to that of the case at bar. Several employees of an employer brought suit against their group health insurer to obtain payment of medical bills incurred during a period when there would have been group health insurance but for the group health insurer's retroactive cancellation of the policy because of the failure of the employer to make premium payments. Just as in the case at bar, the employer in *Willett* continued to deduct the employees' portion of the health insurance premium from their paychecks even though the employer was failing to send that premium to the insurer. Again like the case at bar, once the first non-payment by the employer occurred, discussions then ensued between the insurer and the employer. Negotiations eventually broke down and on March 21, 1988, defendant group health insurer retroactively cancelled the policy from November 1, 1987. One week later on March 28, 1988,

the employees were finally informed by the employer of the retroactive cancellation. All of the plaintiffs in *Willett* sustained health care expenses during the time period of November 1, 1987 to March 28, 1988.

The Eleventh Circuit stated as follows:

> Providing notice of the discontinuation or suspension of coverage is a fiduciary responsibility; employees are entitled to prompt notice of the suspension of their plan coverage.

953 F.2d at 1340.

The Eleventh Circuit held that, although the Master Contract between the group health insurer and employer delegated the duty of notification to the employer (unlike the case at bar), the analysis could not end there. The Court went on to analyze the issue in light of *§ 405* of ERISA, (29 U.S.C. § 1105) which deals with liability by a fiduciary for a breach of duty by a co-fiduciary. The Court found that under this section of ERISA, there may be liability on the part of the group health insurer for the losses that had been incurred by the employees, and therefore remanded the matter for factual findings on the issue of the group health insurer's knowledge that the employer was not notifying the employees of its failure to pay premiums.

The Court also stated that the group health insurer could be found liable, even though it was not initially aware that the employer had not informed the employees of suspension of coverage, *if the group health insurer's agents affirmatively represented to the employees that there was coverage in effect.* 953 F.2d at 1341-1342.

The Eleventh Circuit succinctly summarized its holding as follows:

> If Blue Cross knew that Mays had failed to inform the beneficiaries about the suspension of plan coverage for non-payment of premiums, then it had an obligation to cure the breach.

953 F.2d at 1343.

Although the importance of the holding in *Willett* and its significance to the case at bar was briefed to the Sixth Circuit, inexplicably the opinion below did not address this issue. It is petitioners' position that, given the similarity of the facts of the instant litigation with those of *Willett*, that they should be allowed to proceed on a § 405 theory, even though this particular section of the ERISA statute was not specifically pled. Petitioners fully set forth the factual basis for their complaint against respondent and identified that they were seeking equitable relief pursuant to ERISA, in petitioners' First Amended Complaint.

CONCLUSION

If the opinion below of the Sixth Circuit is allowed to stand, there will be the incongruous result of a fiduciary breaching duties owed to beneficiaries of an ERISA governed group health plan thereby causing the beneficiaries to incur hundreds of thousands of dollars of medical bills, the payment and/or reimbursement of which is denied by the fiduciary, but with there being absolutely no relief for the victims. Put more succinctly, the question presented by this case is whether, under any circumstances, a fiduciary can be held accountable for either contractual or extra-contractual damages caused by breach of fiduciary duties to individual plan participants? This Court should grant certiorari in this matter to explicitly answer this question rather than allow the dicta in Russell to continue to mislead the lower courts in their analysis of ERISA rights under § 502(a)(3) and other provisions.

WHEREFORE, for the reasons set forth above, a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Sixth Circuit in this matter.

Respectfully submitted,

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Dated: March 17, 1994

APPENDIX A — OPINION OF THE COURT OF APPEALS REPORTED IN *TREGONING, ET AL. V. AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY*, 12 F.3D 79 (6TH CIR. 1993)

No. 92-2253

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

BARBARA J. TREGONING; JOE W. HUTCHINS; JOANN HARTLERODE; and RIPLEY LANCE PETERSON,
Plaintiffs-Appellants,

v.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY,
Defendant-Appellee.

ON APPEAL from the United States District Court for the Western District of Michigan

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Decided and Filed December 17, 1993

Before: BOGGS and SUHRHEINRICH, Circuit Judges; and BROWN, Senior Circuit Judge.

BOGGS, Circuit Judge, delivered the opinion of the court, in which SUHRHEINRICH, Circuit Judge, joined. BROWN, Senior Circuit Judge, concurred in the result.

BOGGS, Circuit Judge. The plaintiffs failed to receive health benefits under their employer's ERISA plan because the employer stopped paying into the benefits fund. The district court granted summary judgment to the defendant, American Community Mutual Insurance

Company ("American"), on plaintiffs' Employee Retirement Income Security Act ("ERISA") claims under 29 U.S.C. § 1109(a) and § 1132(a)(3)(B).

We hold that the plaintiffs have failed to plead a legally cognizable claim under 29 U.S.C. § 1109(a) and have failed to carry their burden of proof on their claim under 29 U.S.C. § 1132(a)(3)(B). Accordingly, we affirm the district court's order granting summary judgment to the defendant.

I

The plaintiffs are all former employees of the now-bankrupt Watervliet Paper Company. In March 1989, Watervliet contracted with American for American's services in administering a health benefit plan. Under this agreement, Watervliet agreed to make an initial deposit into a claims fund. American then used this fund to pay out claims. Watervliet deducted payments from employees' paychecks and should have used these deductions to replenish the fund. Watervliet was obligated under the contract to pay American on a monthly basis both for amounts that American paid from the fund and for American's service fee for administering the fund.

Under the terms of the agreement, American had no duty to pay claims if Watervliet did not replenish the fund within twenty days of billing. Watervliet, however, was consistently tardy in replenishing the fund and American sent past due notices to Watervliet in October, November, and December of 1989.

American suspended payment of claims on January 10, 1990. However, when Watervliet made a partial payment, American resumed payment of claims on January 24, 1990. On February 9, American again

suspended payment of claims. After several unsuccessful attempts to work out a payment schedule for Watervliet, American informed Watervliet on May 17, 1990 that it had terminated the policy for non-payment. The cancellation was effective for all claims filed after December 31, 1989.

American never notified the plaintiffs of the problems it was encountering with Watervliet. In fact, on March 23, 1990, a hospital financial counselor contacted American about coverage for a Watervliet employee/plaintiff. American verified that the employee was still covered and gave the counselor the terms of the insurance coverage.

Also, Intracorp, American's agent for certification of employees for health care, continued to certify Watervliet employees for medical treatments through March 1990. Intracorp, however, always sent letters to the employees stating that certification was not a guarantee of payment, and that "such benefits are subject . . . to eligibility, coverage, and contract limitations."

In June 1990, Watervliet laid off the plaintiffs and informed them that American would not honor any medical claims that occurred after December 31, 1989. The plaintiffs filed this complaint in July 1991. The district court granted summary judgment to American in August 1992, and the plaintiffs filed this timely appeal.

II

A

This court reviews *de novo* the district court's grant of defendant's motion for summary judgment. *Baggs v. Eagle-Picher Indust. Inc.*, 957 F. 2d 268, 271 (6th Cir.), *cert. denied*, 113 S. Ct. 466 (1992). This court will affirm the district court only if it determines that the

pleadings, affidavits, and other submissions show "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). The district court must view all evidence before it in the light most favorable to the non-moving party. *Matsushita Elec. Indust. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S. Ct. 1348, 1356 (1986).

The moving party need not support its motion with evidence disproving the non-moving party's claim, but need only "'show[ ]'-- that is, point[ ] out to the district court -- that there is an absence of evidence to support the nonmoving party's case." *Celotex Corp. v. Catrett*, 477 U.S. 317, 325, 106 S. Ct. 2548, 2554 (1986). The pivotal question is whether the party bearing the burden of proof has presented a jury question as to each element of its case. 477 U.S. at 322, 106 S. Ct. at 2552. The plaintiff must present more than a scintilla of evidence in support of his position; the evidence must be such that a jury could reasonably find for the plaintiff. *Anderson v. Liberty Lobby. Inc.*, 477 U.S. 242, 252, 106 S. Ct. 2505, 2512 (1986).

B

As a preliminary matter, we note that ERISA applies to the health plan in issue. *See International Resources, Inc. v. New York Life Ins. Co.*, 950 F.2d 294, 297 (6th Cir. 1991), *cert. denied*, 112 S. Ct. 2941 (1992) (mere purchase of group health insurance policy qualifies as an ERISA welfare benefit plan if the employer does not retain control, administrative power, or responsibility for paying the benefits). The plaintiffs' first claim is that American is a fiduciary within the meaning of 29 U.S.C.

§ 1002(21)(A),[1] and that it is liable under 29 U.S.C. § 1109(a) for its breach of fiduciary duties.[2] Specifically, the plaintiffs contend that American had a duty to notify the plaintiffs that their benefits were in jeopardy due to Watervliet's failure to pay premiums and replenish the fund.

The district court, relying on *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54 (4th Cir. 1992), *cert. denied*, 113 S. Ct. 1051 (1993), found that American was not a fiduciary under ERISA. In *Coleman*, the Fourth Circuit Court of Appeals considered a remarkably similar set of facts to determine if the insurance company was a fiduciary within the meaning of 29 U.S.C. § 1002(21)(A).

In *Coleman*, the plaintiff was covered under her husband's health benefit plan. The husband's employer

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[1] 29 U.S.C. § 1002(21)(A) provides in pertinent part:

> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

[2] 29 U.S.C. § 1109(a) provides in pertinent part:

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

made an initial, but inadequate, premium payment and never made another monthly payment. The employer ultimately went out of business and the insurance company cancelled the policy as of its effective date. *Id.* at 56. Meanwhile, the plaintiff, who was pregnant, incurred hospital expenses. *Id.* at 57. The plaintiff claimed that Nationwide had breached its fiduciary duty to her by not notifying her that the employer's non-payment was jeopardizing her health insurance coverage. *Id.* at 60.

The Fourth Circuit adopted a two-part analysis to determine when an insurance company is a fiduciary. Under the first part, the court examined "the discretionary authority or responsibility of the person with respect to that function." *Id.* at 61. Since that review failed to reveal any discretionary function described in the plan documents, the court next looked to the actions of the insurance company to see if it had voluntarily assumed duties that gave rise to fiduciary obligations. *Ibid.*

Despite the similarity between the facts in *Coleman* and this case, we analyze the fiduciary issue differently. In *Libbey-Owens-Ford Co. v. Blue Cross and Blue Shield Mut.*, 982 F.2d 1031 (6th Cir.), *cert. denied*, 114 S. Ct. 72 (1993), we held that "[w]hen an insurance company administers claims for an employee welfare benefit plan and has authority to grant or deny the claims, the company is an ERISA 'fiduciary' under 29 U.S.C. § 1002(21)(A)(iii)." *Id.* at 1035. In *Libbey-Owens-Ford*, the court found that Blue Cross was a fiduciary as defined by ERISA and, as a fiduciary, was obligated to provide an accounting to Libbey-Owens-Ford on demand.

Under the welfare benefit plan in that case, Libbey-Owens-Ford paid the costs of providing benefits directly to Blue Cross instead of buying insurance from Blue Cross. In return, Blue Cross administered the claims and

decided matters of coverage. Blue Cross provided Libbey-Owens-Ford with monthly statements of amounts paid to health care providers, and it charged a monthly fee for administration of the plan. Blue Cross had the sole authority to resolve all disputes regarding coverage. *Id.* at 1032.

The holding in *Libbey-Owens-Ford* compels the conclusion that American is a fiduciary in this case. According to the plan documents, American had the sole authority "to determine the benefits to which an insured person may be entitled" and Watervliet expressly granted this discretionary authority to American. American's authority to grant or deny claims is the crucial factor that makes it a fiduciary within the terms of 29 U.S.C. § 1002(21)(A)(iii).

Even though American is a fiduciary under ERISA, the plaintiffs cannot recover in their individual capacities. In this case, the plaintiffs have alleged that American's fiduciary duties under 29 U.S.C. § 1109(a) run to them as individuals rather than to the plan as a whole. The plaintiffs, however, have misread this provision.

In *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S. Ct. 3085 (1985), the Supreme Court held that 29 U.S.C. § 1109(a) provides relief only for a *plan* and not for individual participants. 473 U.S. at 140-44, 105 S. Ct. at 3089-91. The Supreme Court noted that "the relevant fiduciary . . . [is] characterized at the outset [of 29 U.S.C. § 1109(a)] as one 'with respect to a plan,'" and the liability of a fiduciary is to reimburse the plan, not the individual participants. 473 U.S. at 140, 105 S. Ct. at 3089. *See also Richards v. General Motors Corp.*, 991 F.2d 1227 (6th Cir. 1993) (plaintiff may not recover under § 1109 for personal losses suffered as a result of poor management of an ERISA plan); *Bryant v. International Fruit Prod. Co.*, 886 F.2d 132 (6th Cir.

1989) (plaintiff may not recover under § 1109 for personal pension benefits lost where recovery is sought on his own behalf rather than on behalf of the plan).

In their complaint, the plaintiffs alleged "[t]hat pursuant to 29 USC § 1109, defendant American has breached its responsibilities, obligations and/or duties as a fiduciary and therefore is personally liable *to plaintiffs* for their damages." (Emphasis added). *Russell* and the Sixth Circuit cases cited *supra*, however, dictate that any recovery under § 1109 will inure to the benefit of the plan as a whole rather than to the participants as individuals. Since the plaintiffs' claim is directly contrary to our precedents, we hold that the plaintiffs cannot recover for their losses under 29 U.S.C. § 1109.

This conclusion is consistent with the holding of *Libbey-Owens-Ford*. In that case, the court found that Libbey-Owens-Ford could bring suit for an accounting of rebates received by Blue Cross. Libbey-Owens-Ford, however, filed for the accounting on behalf of the plan, not on behalf of individual participants, and its claim was based on general principles of trust law, rather than 29 U.S.C. § 1109. *See Libbey-Owens-Ford*, 982 F.2d at 1035.

C

The plaintiffs also allege an equitable estoppel claim under 29 U.S.C. § 1132(a)(3)(B). The Sixth Circuit has incorporated the doctrine of equitable estoppel into the federal common law of contracts, so far as the agreement at issue is before the federal court as an ERISA claim. *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1298 (6th Cir. 1991). The elements of equitable estoppel are

> 1) conduct or language amounting to a representation of material fact;
> 2) awareness of the true facts by the party to be estopped;

> 3) an intention on the part of the party to be estopped that the representation be acted on, or conduct toward the party asserting the estoppel such that the latter has a right to believe that the former's conduct is so intended;
> 4) unawareness of the true facts by the party asserting the estoppel; and
> 5) detrimental and justifiable reliance by the party asserting estoppel on the representation.

Ibid.

In this case, the district court found that, although plaintiffs asserted an equitable estoppel claim in their first amended complaint, they never mentioned the argument in their briefs, and at oral argument, the plaintiffs continually characterized their action as a breach of fiduciary duty case. The court concluded that the plaintiffs had "more than failed to shoulder their burden of supporting this theory," and granted summary judgment to American on the 29 U.S.C. § 1132 claim."[3]

The plaintiffs, however, contend that they did not abandon the claim since the district court had before it affidavits that indicated that American had verified coverage and then refused to pay the claim. Plaintiffs argue that "[i]t only takes a small semantic leap from a claim that defendant American's representation of verification of coverage was unreasonable to a claim that defendant American should be estopped from denying coverage because of those representations."

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[3]The plaintiffs brought their equitable estoppel claim under 29 U.S.C § 1132(a)(3)(B), which provides in pertinent part:

> "A civil action may be brought. . . (3) by a participant, beneficiary, or fiduciary . . . (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan."

Even if this court were willing to make the semantic leap, the district court was correct in granting summary judgment to American. The plaintiffs' main argument on appeal is that since American and Intracorp made representations to the plaintiffs that they were covered by insurance, American is now bound by those representations. Assuming that the plaintiffs could meet their burden as to the first three *Armistead* elements, summary judgment is still appropriate because they cannot meet the last two elements, namely "unawareness of the true facts by the party asserting the estoppel," and "detrimental and justifiable reliance."

American issued a certificate of coverage to the plaintiffs that indicated that American would only pay claims as long as Watervliet's account was in good standing, and it reserved the right to stop paying claims even though the claims occurred before American informed Watervliet of the effective date of the cancellation. Also, Intracorp was careful to inform the plaintiffs that certification did not guarantee that their claims would be paid. Consequently, the plaintiffs were aware that American could cancel if Watervliet fell into arrears and that Intracorp's certification procedures did not guarantee that the claims would be paid.

This uncontroverted evidence was before the district court. Since the plaintiffs failed to challenge this evidence, the district court was correct in granting summary judgment to American on the equitable estoppel claim.

The district court's order granting summary judgment to American is therefore AFFIRMED.

BROWN, Senior Circuit Judge, concurs in the result.

APPENDIX B — ORDER OF THE DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN DENYING MOTION FOR RECONSIDERATION DATED AUGUST 27, 1992

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case No. 1:91-CV-605

HON. ROBERT HOLMES BELL

BARBARA J. TREGONING, JON W. HUTCHINS, JOANN HARTLERODE and LANCE RIPLEY PERTERSEN, Individually and on behalf of all other similarly situated,

Plaintiffs,

v.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY, a Michigan Corporation, INTRACORP, INC., a Delaware Corporation and INDUSTRIAL INSURANCE SERVICES, INC., a Michigan Corporation,

Defendants.

ORDER

In accordance with the written opinion issued this date, the plaintiffs' motion for reconsideration under Fed. R. Civ. P. 59(e) is hereby DENIED.

IT IS SO ORDERED.

Dated: August 26, 1992

s/ Robert Holmes Bell
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

APPENDIX C — OPINION OF THE DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN DENYING MOTION FOR RECONSIDERATION DATED AUGUST 27, 1992, REPORTED IN *TREGONING, ET AL V. AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY,* 815 F. SUPP. 1054 (W.D. MICHIGAN, S.D. 1992) DATED AUGUST 27, 1992

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Case No. 1:91-CV-605

HON. ROBERT HOLMES BELL

BARBARA J. TREGONING, JON W. HUTCHINS, JOANN HARTLERODE and LANCE RIPLEY PERTERSEN, Individually and on behalf of all others similarly situated,

Plaintiffs,

v.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY, a Michigan Corporation, INTRACORP, INC., a Delaware Corporation and INDUSTRIAL INSURANCE SERVICES, INC., a Michigan Corporation,

Defendants.

OPINION

In this ERISA case, the plaintiffs move for reconsideration under Fed. R. Civ. P. 59(e).[1] Plaintiffs argue that the Court's July

1. Plaintiffs actually neglected to label their reconsideration motion. However, (Cont'd)

Appendix C

15, 1992 Opinion and Order, granting summary judgment in favor of the sole remaining defendant, was erroneous. For reasons that follow, the motion is DENIED.[2]

I.

On July 14, 1992, this Court issued its Opinion and Order, granting summary judgment in favor of defendant American Community Mutual Insurance Company ("American") and denying the same to the plaintiffs. The Court concluded that the plaintiffs could not withstand summary judgment on the only remaining claim — the ERISA claim — in the plaintiffs' First Amended Complaint. The Court explained that the plaintiffs' two ERISA theories — one under 29 U.S.C. § 1109(a) and the other under 29 U.S.C. § 1132 — had failed.

The Court had two separate reasons. First, the section 1132 theory failed because the plaintiffs had neglected to address that theory throughout the summary judgment proceeding. *See* Opinion and Order at 7-9. And second, the section 1109(a) theory failed because American was not, as a matter of law, an ERISA fiduciary as to the notification function at issue. *See id.* at 9-14. The Court

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(Cont'd)
since the plaintiffs urge this Court to, in effect, "alter or amend" the Court's grant of summary judgment in favor of defendant American Community Mutual Insurance Company ("American") and since the plaintiffs have served the motion to American within ten days after entry of judgment, it appears that the motion can be considered as a motion based on Fed. R. Civ. P. 59(e). *See* Fed. R. Civ. P. 59(e); *Columbia Gas Transmission Corp. v. Limited Corp.*, 951 F.2d 110, 112 (6th Cir. 1991).

2. The background facts and procedural history of this case are adequately recited in the Court's Opinion and Order of July 14, 1992. There is no need to repeat them here.

also noted that because of the second reason, regarding the section 1109(a) theory, there was no need to reach any other arguments raised by the plaintiffs. *See id.* at 14.

In response, the plaintiffs have timely moved for reconsideration under Fed. R. Civ. P. 59(e).

II.

Plaintiffs principally contend that reconsideration and reversal are required because the Court did not consider and follow a recent Eleventh Circuit case. In addition, the plaintiffs argue that the Court did not address one of the plaintiffs' claims.

Upon careful review, the Court finds neither of the arguments persuasive. It therefore concludes that there is no valid basis to disturb the Court's conclusions set forth in the July 14, 1992 Opinion and Order. The reasons follow.

1. Plaintiffs' reliance on the recent Eleventh Circuit decision in *Willett v. Blue Cross & Blue Shield,* 953 F.2d 1335 (11th Cir. 1992), is misplaced. Contrary to the plaintiffs' contention, the *Willett* case is not applicable here.

In *Willett,* the Eleventh Circuit discussed the issue of whether a fiduciary of an ERISA plan had a duty to notify the beneficiaries that their medical coverage had been suspended for non-payment of premium by a co-fiduciary of the plan, in light of the co-fiduciary's failure to directly notify the beneficiaries on the suspension. *See* 953 F.2d at 1340-42. The *Willett* court, however, did not address the predicate issue of whether the party charged with liability under 29 U.S.C. § 1105(a) was an ERISA fiduciary under 29 U.S.C. § 1002(21)(A). Apparently, the fiduciary status of that defendant was not disputed in *Willett.*

By contrast, the parties in this case vigorously contested the foundation issue of whether American was an ERISA fiduciary under 29 U.S.C. § 1002(21)(A). In fact, this Court granted summary judgment in favor of American under the section 1109(a) theory on the grounds that American was not an ERISA fiduciary as to the notification issue at hand. *See* Opinion and Order at 9-14. Further, the Court noted that since American had not qualified as an ERISA fiduciary under section 1002(21)(A), there was no need to reach any other questions, such as whether American had a fiduciary duty to notify, as the *Willett* court did. *See* Opinion and Order of July 15, 1992 at 14. In short, since this case involved a different issue, there was no need to consider *Willett.*

2. Equally unavailing is the plaintiffs' other contention that the Court did not address one of the plaintiffs' claims — the "equitable estoppel claim." The Court believes, after reviewing the record, that it has adequately disposed of the claim.

Plaintiffs' *state* law equitable estoppel claim — which appears to be part of Count IX of the First Amended Complaint ("Estoppel and Detrimental Reliance" claim) — was dismissed on the grounds of ERISA federal preemption on October 10, 1991, long before the summary judgment proceeding. *See* Hearing Transcript of October 10, 1991; *see also* Opinion and Order at 5.

And as to the *federal* equitable estoppel claim, the plaintiffs' written summary judgment submissions did not clearly identify such a claim. Plaintiffs, while submitting certain affidavits, did not specifically mention an estoppel claim during the oral argument, *see* Hearing Transcript of February 7, 1992 at 24-26; indeed, the plaintiffs' singular focus was on the breach of fiduciary claim under 29 U.S.C. § 1109(a). *See* Opinion and Order at 8. But even if the plaintiffs had properly identified and advanced the estoppel

claim at the summary judgment proceeding, it appears that the claim was nothing more than a part of the 29 U.S.C. § 1132 theory, *see* First Amended Complaint, Count XVIII, ¶ 172B, which this Court addressed and rejected. *See* Opinion and Order of July 15, 1992 at 7-9. Thus, it cannot be said that the Court overlooked the "equitable estoppel claim."

III.

For the reasons given above, the plaintiffs' motion for reconsideration under Fed. R. Civ. P. 59(e) is hereby DENIED. An order consistent with this opinion shall issue forthwith.

Dated: August 26, 1992

s/ Robert Holmes Bell
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

APPENDIX D — OPINION AND ORDER OF THE DISTRICT COURT FOR THE WESTERN DISTRICT OF MICHIGAN GRANTING MOTION FOR SUMMARY JUDGMENT DATED JULY 15, 1992, REPORTED IN *TREGONING, ET AL. V. AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY*, 815 F. SUPP. 1054 (W.D. MICHIGAN, S.D. 1992) DATED JULY 15, 1992

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

File No. 1:91-CV-605

HON. ROBERT HOLMES BELL

BARBARA J. TREGONING, JOE W. HUTCHINS, JOANN HARTLERODE, and RIPLEY LANCE PERTERSEN, Individually and on behalf of all others similarly situated,

Plaintiffs,

v.

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY, a Michigan Corporation, INTRACORP, INC., a Delaware Corporation and INDUSTRIAL INSURANCE SERVICES, INC., a Michigan Corporation,

Defendants.

OPINION AND ORDER

In this ERISA case, the remaining parties cross-move for summary judgment under Fed. R. Civ. P. 56. For the reasons set forth below, the plaintiffs' motion is DENIED and defendant

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American Community Mutual Insurance Company's motion is GRANTED.

I. BACKGROUND

A.

Defendant American Community Mutual Insurance Company ("American") provides group health insurance policies and self-insured arrangements to various companies. Watervliet Paper Company, Inc. ("Watervliet"), a non-party to this action, is currently in Chapter 11 bankruptcy. Plaintiffs are former employees of Watervliet.

In early 1989, American and Watervliet entered into a contract, called the Minimum Premium Agreement ("Agreement"). The Agreement provided that American would issue a group health policy, which, together with the Agreement, constituted a self-funded employee benefit plan ("Plan") under ERISA, *see* 29 U.S.C. § 1002, to Watervliet. The policy, effective March 6, 1989, provided coverage of various health care claims to the Plan beneficiaries. Watervliet's employees, including the plaintiffs, were the beneficiaries; they contributed, through a payroll deduction, a portion of Watervliet's premium paid to American.

Under the Agreement, Watervliet was first required to make a deposit of $98,753.16 into a cash reserve, called "Claims Fund." From this reserve, American paid the employees' health care claims on behalf of Watervliet.

To replenish the cash reserve, Watervliet was then billed for reimbursements each month. Watervliet had to remit its monthly

reimbursements within 20 days of billing. In the event that Watervliet did not comply with the billing schedule, American had the right to stop its payment of the employees' health care claims, as well as to terminate the Agreement and the policy.

There was, however, no provision in the Agreement — or elsewhere in the policy — that mandated American to provide notice to Watervliet's employees, including the plaintiffs, of Watervliet's failure to remit its premium or reimbursement payments.

B.

Almost from the beginning, Watervliet, a financially-strapped company, had trouble paying its full monthly reimbursements in a timely fashion. American sent a number of overdue notices, including notices threatening termination of the policy. Nevertheless, Watervliet continued to fall behind on its payments. Indeed, by December 1989, Watervliet had initially stopped making its payments altogether.

On January 10, 1990, American preliminarily suspended any further payment of the employees' claims. Still, as Watervliet made additional — subsequent — reimbursement payments, American, combining those partial payments with the funds in the cash reserve, began to resume its payments of the employees' claims. For the next few months, American continued to pay the employees' pre-December 31, 1989 claims.

During those months, however, it became clear to American that Watervliet would never pay all the reimbursements necessary to completely replenish the cash reserve. In fact, because of Watervliet's recurring failure to pay the full reimbursements, the

funds in the reserve were close to being depleted. American therefore decided to terminate the Watervliet's policy pursuant to the Agreement.

By letter of April 12, 1990, American informed Watervliet that it was terminating the policy, effective February 28, 1990, on the grounds of Watervliet's non-payment. That letter also informed Watervliet to notify all employees covered under the policy that the coverage had ended, and that American was not liable for any claims or losses after the termination date, unless otherwise provided in the policy. By another letter, dated May 17, 1990, American clarified to Watervliet that the effective termination date of the policy was December 31, 1989.

Meanwhile, neither American nor Watervliet notified the plaintiffs that Watervliet was failing to make its required monthly reimbursements. Nor did they give any prior notice about the termination of the coverage to the plaintiffs and other employees. Moreover, American's authorized agent, Intracorp, Inc. ("Intracorp") continued to provide pre-certification and other ancillary coverage services to the plaintiffs.

In early June 1990, Watervliet's business soured further. Watervliet was compelled to lay off its employees, including the plaintiffs. Concurrently, the plaintiffs learned, for the first time, that their health care insurance coverage had lapsed on December 31, 1989 for Watervliet's failure to make its premium and reimbursement payments. American therefore refused to pay or reimburse the employees' health care claims incurred after that date. Subsequently, Watervliet filed for bankruptcy.

This action ensued.

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C.

Initially, the plaintiffs, suing for themselves and on behalf of all of the 200-plus employees of Watervliet who were affected by the lapse of the policy, filed a state court complaint in the Berrien County Circuit Court on May 22, 1991. The state court complaint alleged a host of state law claims related to the cancellation of the group health insurance policy against American Community and other former defendants, Intracorp, and Industrial Insurance Services, Inc. ("Industrial").[1]

On July 17, 1991, American removed the case to this Court on the basis of federal question jurisdiction. On August 15, 1991, the plaintiffs amended their complaint to add an ERISA claim.

On October 10, 1991, the Court dismissed, by a bench ruling, all the state law claims in the First Amended Complaint on the grounds of ERISA preemption. *See* Hearing Transcript of October 10, 1991.

D.

The only remaining claim is the ERISA claim. *See* First Amended Complaint, Count XVIII. Under the claim, the plaintiffs allege two theories: (1) that American, as a fiduciary of the ERISA Plan, breached its fiduciary duty to the plaintiffs, the Plan beneficiaries (pursuant to 29 U.S.C. § 1109(a)); and (2) that American, even if it were not a fiduciary, must comply with the terms of the Plan by paying all the employees' health care claims

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1. Subsequently, both Intracorp and Industrial have been dismissed from this action. *See* Stipulation and Order of Dismissal Without Prejudice, filed November 22, 1991.

that were otherwise payable but for American's termination of the policy (pursuant to 29 U.S.C. § 1132). *See* First Amended Complaint ¶¶ 165-173.

II. DISCUSSION

At this time, the parties cross-move for summary judgment on the remaining ERISA claim. In their cross-motions, both parties, without expressly stating so, agree that there is no triable issue of fact. The parties then advance their own legal arguments.

In support of its motion, American makes two contentions. First, the actual language of the ERISA Plan — comprising of the Agreement and the policy — shows that American had no duty to continue paying the plaintiffs' health care claims after Watervliet failed to make full reimbursement payments; in other words, American's denial of the plaintiffs' health care claims was not contrary to the terms of the Plan. Second, American breached no ERISA fiduciary duty by not notifying the plaintiffs of Watervliet's failure to meet its payment obligations to American.

On the other hand, the plaintiffs return with one argument. They assert that, independent of the terms of the Plan, American breached its ERISA fiduciary duty by not notifying the plaintiffs of Watervliet's failure to meet its obligations to American and by allowing its authorized agent, Intracorp, to continue to provide pre-certification and other services to the plaintiffs.

A.

Under Rule 56(c) of the Federal Rules of Civil Procedure, summary judgment is appropriate if "there is no genuine issue as to any material fact and that the moving party is entitled to a judgment

as a matter of law." To be genuine, the dispute must concern evidence upon which "a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

To meet this standard, "the burden on the moving party may be discharged by 'showing' — that is, pointing out to the district court — that there is an absence of evidence to support the nonmoving party's case." *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). It requires a determination of whether the party bearing the burden of proof has presented a jury question as to each element of its case. *Celotex*, 477 U.S. at 322. "In other words, the movant could challenge the opposing party to 'put up or shut up' on a critical issue." *Street v. J.C. Bradford & Co.*, 886 F.2d 1472, 1478 (6th Cir. 1989).

In determining a summary judgment motion, "[t]he mere existence of a scintilla of evidence in support of the plaintiff's position will be insufficient; there must be evidence on which the jury could reasonably find for the plaintiff." *Anderson*, 477 U.S. at 252. Accordingly, viewing the evidence in the light most favorable to the nonmoving party, the court should determine "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson*, 477 U.S. at 251-52.

In this case, there is no genuine issue of material fact, and summary judgment is therefore ripe.

B.

In the First Amended Complaint, the plaintiffs allege a separate theory under 29 U.S.C. § 1132. *See* First Amended

Complaint ¶¶ 169-172. Under that theory, the plaintiffs assert that American, in contravention to the ERISA Plan at issue, denied the plaintiffs' health care claims.

In these motions, however, the plaintiffs focus only on the breach of fiduciary duty theory under 29 U.S.C. § 1109(a). More precisely, the plaintiffs contend that:

> [their] position is that American owed a duty to plaintiffs as a fiduciary pursuant to ERISA, and that American violated this duty by failing to notify plaintiffs that their employer, Watervliet Paper Company ("Watervliet"), had failed to pay the amounts due to American, specifically monthly reimbursement to American of amounts paid from the claims fund by American and monthly payment of a minimum premium.

Plaintiffs' Opening Brief at 1. In the same vein, the plaintiffs also argue that "American owed plaintiffs a duty to use reasonable care and diligence," and that American violated this duty by allowing Intracorp to "continue to provide pre-certification and other services to the plaintiffs." *Id.* at 1-2.

Moreover, in their reply brief in support of their motion, the plaintiffs exclusively address the central issue of the section 1109(a) theory: whether American breached its fiduciary duty under ERISA by failing to notify the plaintiffs of Watervliet's failure to fully remit the monthly reimbursements. *See generally* Plaintiffs' Reply Brief. And finally, at oral argument, the plaintiffs repeatedly characterized this action as a breach of fiduciary duty case. *See, e.g.*, Hearing Transcript for Cross-motions for Summary Judgment at 14, 26, 31.

In other words, despite their allegations in the First Amended Complaint, the plaintiffs in the summary judgment briefings and hearing have made no reference to the section 1132 theory; that American, in contravention to the ERISA Plan, denied the plaintiffs' health care claims. In so doing, the plaintiffs have more than failed to shoulder their burden of supporting this theory; they have outright abandoned it. The section 1132 theory therefore cannot stand. Summary judgment in favor of American must be GRANTED on this theory.[2]

C.

Next, the more difficult question concerns the heart of the instant case — the section 1109(a) theory. The question is whether American breached its fiduciary duty under ERISA by not notifying the plaintiffs of Watervliet's failure to fulfill its premium and reimbursement obligations. Plaintiffs urge the Court to answer this question in the affirmative. The Court cannot.

(1)

To prevail on a breach of fiduciary theory, based on 29 U.S.C. § 1109(a), the plaintiff must first establish that the defendant is an ERISA "fiduciary." Plaintiff need not, however, be expressly named as a "fiduciary" in the plan documents to be one. *See Associates in Adolescent Psychiatry. S.C. v. Home Life Ins. Co.*, 941 F.2d 561, 568 (7th Cir. 1991), *cert. denied*, 112 S. Ct. 1182 (1992). Rather, the plaintiff qualifies as a "fiduciary," if he falls under the ERISA definition of the term. *Id.*

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2. The Court recognizes that a breach of fiduciary duty claim may be brought pursuant to section 1132. *See Falcche v. Sun Life Assur. Co.*, 958 F.2d 730, 733 (6th Cir. 1992). Accordingly, the foregoing discussion applies to the extent that the section 1132 theory is separate from the section 1109(a) theory, as it appears to be the case here.

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The statute defines the term "fiduciary" as follows:

> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A). Consistent with the congressional intent to safeguard the interests of ERISA participants and their beneficiaries, courts — in this Circuit and elsewhere — have generally construed the term "fiduciary" broadly. *See, e.g., Brock v. Hendershott,* 840 F.2d 339, 342 (6th Cir. 1988); *Landry v. Air Line Pilots Ass'n International,* 901 F.2d 404, 417 (5th Cir. 1990); *Mutual Life Ins. Co. v. Yampol,* 840 F.2d 421, 425 (7th Cir. 1988).

But there are certain limits to that broad construction. One of them is the "strict limiting effect on the definition of 'fiduciary' that is imposed by the qualifying phrase 'to the extent.' " *Licensed Div. Dist. No. 1 MEBA/NMU v. Defries,* 943 F.2d 474, 477 (4th Cir. 1991), *cert. denied,* 112 S. Ct. 972 (1992). That qualifying phrase "indicates that a person is a fiduciary only with respect to those aspects of the plan over which he exercises authority or control." *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises. Inc.,* 793 F.2d 1456, 1459-60 (5th Cir.

1986), *cert. denied*, 479 U.S. 1034 (1987); *see also Coleman v. Nationwide Life Ins. Co.*, __ F.2d __, 1992 U.S. App. LEXIS 15011, at * 19-20 (4th Cir. July 1, 1992) ("The statutory language plainly indicates that the fiduciary function is not an indivisible one."); *Hozier v. Midwest Fasteners. Inc.*, 908 F.2d 1155, 1158 (3d Cir. 1990) ("Fiduciary duties under ERISA attach not just to particular persons, but to particular persons performing particular functions."); *Leigh v. Engle*, 727 F.2d 113, 133 (7th Cir. 1984) ("ERISA recognizes that a person may be a fiduciary for some purposes and not others.").

To determine whether a person is a fiduciary with respect to a particular function at issue, the ERISA statute requires an examination of the discretionary authority or responsibility of the person with respect to that function. *See Coleman*, 1992 U.S. App. LEXIS 15011, at * 19-20; *Sommers Drug Stores*, 793 F.2d at 1460. In this examination, an initial review of the ERISA plan documents is required. *Coleman* at * 20. However, should such a review fail to reveal any discretionary authority or responsibility as to the function at issue, a scrutiny beyond the formal allocation of responsibilities must be conducted; the actions of the person who is to be charged as a fiduciary for that function must be further considered. *Coleman* at * 21-22; *see, e.g., Landry*, 901 F.2d at 418-19 (remanding the action to the district court for failing to consider the extent of the actual fiduciary authority possessed or exercised as to certain functions). If neither level of review discloses evidence demonstrating that a person possessed or exercised discretionary authority or responsibility with respect to the function at issue, he is not an ERISA fiduciary for that function. *Coleman* at * 22.

Conducting that two-tier review in this case, the Court concludes that American was not an ERISA fiduciary with respect

to the notification at issue. There was no formal authority or responsibility as to the notification function. Nor did American actually possess or exercise any fiduciary authority or responsibility on that function.

First, there was no formal allocation. The plan documents — the previously described Minimum Premium Agreement and the insurance policy — do not suggest that American had any authority or responsibility to provide notice to the employees of Watervliet regarding Watervliet's failure to meet its monthly premium or reimbursement obligations.[3] Rather, it appears from the letter of April 12, 1990, sent by American to Watervliet regarding the termination of the policy, that it was Watervliet's sole responsibility to notify its employees, including the plaintiffs, regarding its failure to fulfill its obligations. *See* Exhibit 7 to Plaintiffs' Opening Brief. Indeed, at oral argument, the plaintiffs' counsel repeatedly acknowledged as much; the counsel stated six times that the plan documents themselves imposed no such notification responsibility or authority to American. *See* Hearing Transcript for Cross-motions for Summary Judgment at 20, 21, 22, 23, 26, 29.

Second, American did not act as a fiduciary as to the notification function. There is nothing on the record that shows that American acted in any way to voluntarily assume the notification responsibility or authority. And the plaintiffs have not claimed that American had done so. To be sure, had American acted otherwise, the plaintiffs could not have alleged this theory.

Taking an expanded view of the term "fiduciary" and the

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3. In fact, nowhere in the plan documents is there any indication that American was named as a "fiduciary" or an "administrator" with respect to the Plan here.

duties thereunder, the plaintiffs, however, contend that American, as a fiduciary, had an independent duty of notification. In support, the plaintiffs argue that American was a fiduciary because it possessed or exercised discretionary authority or responsibility as to a number of matters unrelated to the notification function at issue.

Plaintiffs' argument is unpersuasive. Their argument is based on a misunderstanding of the concept of fiduciary status. As suggested above, and as the Fourth Circuit — in reversing the district court in *Coleman*, which the plaintiffs principally rely on— aptly stated, fiduciary status is not an "all-or-nothing concept." *Coleman*, 1992 U.S. App. LEXIS 15011, at * 19. A person who may be a fiduciary under an employee welfare benefit plan may not be a fiduciary with respect to a particular function under the plan. *Id.* at 19-20; *see cf. Musto v. American General Corp.*, 861 F.2d 897, 911 (6th Cir. 1988) (a company may act as a fiduciary in performing one task, but not as to another), *cert. denied*, 490 U.S. 1020 (1989). In this case, as explained above, American was not a fiduciary as to the particular function at issue — the notification function. Contrary to the plaintiffs' contention, whether American possessed or exercised a panoply of discretionary authority or responsibility as to matters unrelated to the notification function is of no concern here.

Of course, what the plaintiffs are really urging this Court to do are as follows: (1) to disregard Congress' mandate for adherence to the provisions of the written ERISA plan, *see* 29 U.S.C. § 1102(a)(1), and (2) to adopt, instead, an expanded view of the term "fiduciary," which has been discredited for "judicial inventiveness." *Coleman*, 1992 U.S. App. LEXIS 15011, at * 22. Or to put it more concisely, the plaintiffs invite this Court to redefine the contours of fiduciary status beyond the terms and the

congressional intent of the ERISA statute. For the reasons stated above, this Court cannot — and will not — do so. Summary judgment in favor of American is GRANTED on the section 1109(a) theory as well.[4]

(2)

In light of the foregoing, the Court need not address other arguments raised by the plaintiffs.

III. CONCLUSION

Defendant American Community Mutual Insurance Company's motion for summary judgment is hereby GRANTED and the plaintiffs' cross-motion for the same is hereby DENIED. The action is DISMISSED with prejudice.

The Clerk shall enter judgment in favor of defendant American Community Mutual Insurance Company.

IT IS SO ORDERED.

Dated: *July 14, 1992*

s/ Robert Holmes Bell
ROBERT HOLMES BELL
UNITED STATES DISTRICT JUDGE

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4. Under the same reasoning, American was not a fiduciary as to its actions with respect to Intracorp.